

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00104493</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 10/4/12</p> <p>Facility Number: 005012</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>Saint Joseph Regional Medical Center is in compliance with 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 11/14/12</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

XW2Q11

If continuation sheet 1 of 1